NO STAPLES IN BAR CODE AREA

STATEMENT FOR MISCELLANEOUS SERVICES

Dept. of Labor & Industries
Claims Section
PO Box 44267
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Transportation
- ☐ Home Health/ Nursing Home Services
- ☐ Glasses
- ☐ Vocational/ Retraining
- ☐ Other

DO NOT WRITE IN SPACE >

WORKER'S NAME IN FULL Last	First	Middle	Social Security Number (for ID only)	Claim Number

Address	Employer's Name

City	State	ZIP	Reimburse Injured Worker ☐ Yes ☐ No If yes, receipt required

Date of Injury	Name of referring physician or other source	Referring physician provider number

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
(use ICD-9-CM) Designate left or right when applicable.
1.
2.
3.
4.
5.

For glasses, advise if old Rx was available? ☐ Yes ☐ No

Give hospitalization dates for inpatient services
Admitted ___/___/___
Discharged ___/___/___

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.
CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	P O S *	T O S	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing No of hrs/day	Home Nursing Hourly/ Day rate	GLASSES OLD RX OD	GLASSES OLD RX OS	GLASSES NEW RX OD	GLASSES NEW RX OS	CHARGES $	CHARGES ¢	Unit	TO DATE OF SERVICE
1.																
2.																
3.																
4.																
5.																
6.																
7.																
8.																
9.																
10.																
11.																
12.																
13.																

Submission of this bill certifies the material furnished, service provided, expense incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the state of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Bill date: ___/___/___

Remarks:

Provider or Supplier name	Provider number	Total Charge
Address		Phone Number
City State ZIP + 4		Your Patient's Account Number
Federal tax ID number ☐ EIN ☐ SSN		Referral ID

F245-072-000 statement for misc services 3-04

* Place of Service (POS) and Type of Service (TOS) codes on back

INSTRUCTIONS FOR COMPLETING MISCELLANEOUS SERVICES FORM

1. Place an "X" in the box next to the type of service for which you are billing.
2. **CLAIM NUMBER:** For the injured worker receiving services.

INDUSTRIAL INSURANCE

Claim numbers are six digits, preceded by a "B, C, F, G, H, J, K, L, M, N, P, X or Y." Crime victim claim numbers are six digits preceded by a "V", or five digits preceded by a "VA, VB, VC, VH, VJ or VK". Department of Energy claims are seven digits with no preceding letter.

Send bills for Industrial Insurance claims to:
Department of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

Send bills for Crime Victims claims to:
Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520

SELF INSURANCE

Department bill forms are furnished at no charge to the vendor and can be obtained by calling the local department service location. Self-insurance claim numbers are six digits preceded by an "S, T or W". Bills for all self-insurance claims should be sent directly to the employer or their service company. Department bill forms, self-insured forms, or other forms acceptable to the self-insurer may be used.

3. **INJURED WORKER'S NAME:** Injured worker's full name, last name first.
4. **SOCIAL SECURITY NUMBER:** Record claimant's social security number. It is helpful when the claim number is wrong and the worker's name is common.
5. **ADDRESS:** The injured worker's most current address.
6. **EMPLOYER'S NAME:** The injured worker's employer's name. If the claim number is in error, this helps identify the proper claim.
7. **DATE OF INJURY:** This is important and must be included. One worker may have several claim so it is vital the proper claim be identified and charged for services provided. The date of injury positively identifies each claim.
8. **NAME OF REFERRING PHYSICIAN:** The name of the physician who has referred the claimant to you, the provider, for services. (Not applicable for Vocational Services billing.)
9. **REFERRING PHYSICIAN PROVIDER NUMBER:** The Department of Labor and Industries provider account number of the referring physician. The number may be obtained from the referring physician. (Not applicable for Vocational Services billing.)
10. **DIAGNOSIS:** Indicate both the ICD9-CM number and the narrative diagnosis for all conditions treated. Designate left or right side of body, when applicable. The diagnosis presented must be specific. (Not applicable for Vocational Services billing.)
11. **FOR GLASSES:** Indicate by placing an "X" in the appropriate box.
12. **SERVICES RELATED TO HOSPITALIZATION:** If claimant was hospitalized, record the date admitted and the date discharged.
13. **ITEMIZATION OF SERVICES AND CHARGES:**
    - A. **DATE(s) OF SERVICE:** Record the date for each service provided. For consecutive dates of service, (e.g., home care, attendant care, equipment rental, etc.) record both beginning (from-date-of-service column) and ending (to-date-of-service column) dates.
    - B. **PLACE OF SERVICE:** Place of Service (POS) codes are printed below. Please refer to that list and place the appropriate code in the space provided.
    - C. **TYPE OF SERVICE:** A complete list of Type of Service (TOS) codes is printed below. Please refer to that list and place the appropriate code in the space provided.
    - D. **PROCEDURE CODE:** Identifies the procedures used. Procedure codes can be found in the **Medical Aid Rules and Maximum Fee Schedule** distributed by the Department of Labor and Industries.
    - E. **CODE MODIFIER:** A modified provides the means by which the reporting physician can indicate that a performed service or procedure has been altered by some specific circumstance, but has not changed in its definition or code. When applicable, the modifying circumstance should be identified by the addition of the appropriate "modifier code number" (including the hyphen) after the usual procedure number.
    - F. **DENTAL:** To be used for dental services only.
      Tooth Number: Identify dental services provided by placing the specific tooth number in the appropriate box.
    - G. **HOME NURSING:** To be used for home care only.
      Number of Hours or Days: Identify the number of hours or the number of days that the home care services were provided.
      Hourly or Daily Rate: Record the rate charged (by the hour or day) for the home care services provided.
    - H. **GLASSES:** To be used for glasses repair or replacement only.
      Old Rx (OD and OS): If the old prescription is available, specify for both the left and right eyes.
      New Rx (OD and OS): Specify the new prescription for both the left and right eyes.
    - I. **CHARGES:** Charges for services provided.
      UNIT: The sum total of services provided for days, units, or miles, etc.
14. **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** The provider's or supplier's name and current address. If any of the information changes, notify Provider Accounts immediately. (Indicating a new address on the bill **will not** change the department's record of address for the provider.
15. **PROVIDER NUMBER:** Identification number designated by the Department of Labor and Industries for the provider.
16. **TOTAL CHARGE:** Total of **all** charges for services provided.
17. **YOUR PATIENT'S ACCOUNT NUMBER:** The number used to identify your patient's account.
18. **REFERRAL ID:** Enter the referral ID.
19. **REMARKS:** Any information necessary that the provider or supplier feels is necessary for further explanation.

ATTACHMENTS

The following attachments **must be** submitted with billings for appropriate services:

1. X-ray findings
2. Lab reports
3. Office notes
4. Operative reports
5. Emergency Room reports
6. Diagnostic Study reports
7. Cost invoice of supplies furnished
8. Consultation reports

Each attachment must have the corresponding claim number listed in the upper right corner of the attachment.

DUE TO THE FACT THAT THE DEPARTMENT RECORDS ARE KEPT ON MICROFILM, BILLS AND ATTACHMENTS MUST BE LEGIBLE AND CLEAR.

The following attachment **is not** acceptable: Office Visit Slips.

REBILLS

If you do not receive payment or notification from the department within ninety (90) days, services may be rebilled. Rebills should be identical to the original bill: same charges, codes and billing dates. Please indicate **"Rebill"** on the bill.

Any inquiries regarding adjustment of charges must be submitted within ninety (90) days from the date of payment to be considered.

TYPE OF SERVICE (TOS)		
C Chiropractic Services	N Nurse Practitioner Services	3 Medical Services
D Drugless Therapeutics	O Outpatient	4 Dental
I Inpatient	P Physical Therapy	9 Ancillary Services
	V Vocational Services	(attendant, equipment, glasses)

PLACE OF SERVICE (POS)

- 03. School
- 04. Homeless Shelter
- 05. Indian Health Service Free-standing Facility
- 06. Indian Health Service Provider-based Facility
- 07. Tribal 638 Free-standing Facility
- 08. Tribal 638 Provider-based Facility
- 11. Office
- 12. Patient's Home
- 13. Assisted Living Facility
- 14. Group Home
- 15. Mobile Unit
- 20. Urgent Care Facility
- 21. Inpatient Hospital
- 22. Outpatient Hospital
- 23. Emergency Rm - Hospital
- 24. Ambulatory Surgical Ctr
- 25. Birthing Ctr
- 26. Medical Trmt. Facility
- 31. Skilled Nursing Facility
- 32. Nursing Facility
- 33. Custodial Care Facility
- 34. Hospice
- 41. Ambulance - Land
- 42. Ambulance - Air or Water
- 49. Independent Clinic
- 50. Federally Qualified Hlth Ctr
- 51. Inpatient Psychiatric Facility
- 52. Psychiatric Facility Partial Hospitalization
- 53. Community Mental Health Ctr
- 54. Intermediate Care Facility/Mentally Retarded
- 55. Residential Substance Abuse Trmt Facility
- 56. Psychiatric Residential Trmt Ctr
- 57. Non-residential Substance Abuse Trmt Facility
- 60. Mass Immunization Ctr
- 61. Comprehensive Inpatient Rehabilitation Facility
- 62. Comprehensive Outpatient Rehabilitation Facility
- 65. End Stage Renal Disease Trmt Facility
- 71. State or Local Public Health Clinic
- 72. Rural Hlth Clinic
- 81. Independent Laboratory
- 99. Other Unlisted Facility